#  County Human Services Department Adult Protective Services

Investigation *I* Intake Summary Report

REFERRAL DATE: INTAKE REPORT COMPLETED BY:

**NAME:** WITS INCIDENT #: **DOB:**

AT TEMPORARY ADDRESS? PHONE: SS#:

MAILING ADDRESS:

REFERRAL SOURCE:

COUNTY OF RESIDENCE: PHYSICAL ADDRESS:

APS WORKER ASSIGNED: SUSPECTED DISABILITY:

TYPE OF ALLEGED ABUSE/NEGLECT:

BROWN COUNTY CM *I* COUNTY HISTORY: FAMILY CARE OR IRIS CASE MANAGER:

LIVING ARRANGEMENT:

SEX:

MARITAL STATUS:

VETERAN: NATIONAL ORIGIN:

INCOME *I* BENEFITS *I* ASSETS:

SAVINGS AT: CHECKING AT: INVESTMENTS AT: BENEFITS:

RED FLAGS:

LEGAL DECISION MAKER:

EMERGENCY CONTACT: PHYSICIAN & CLINIC:

FAMILY, FRIENDS OR OTHER CONTACTS:

Service Date:

CLOSING SUMMARY: CLOSED DATE:

RISK LEVEL: TARGET GROUP(S):

COURT TYPE: COURT CASE #:

SUBSTANTIATION: ACTION(S) TAKEN:

CLOSING NARRATIVE: